lation 0.81). Test-retest reliability was also high for all items of the RDQ (reliability coefficient > 0.9) and the readiness for discharge status (tetrachoric correlation 0.82). Overall, 84% of the raters agreed that the RDQ was useful in assessing patients' readiness for discharge. Evidence of good construct validity included significant correlations with PANSS total and factor scores, and a significant relationship with actual discharge. Significantly more patients with symptom improvement were judged ready for discharge (compared to those without symptom improvement), indicating that the RDQ was responsive to change over time. **CONCLUSIONS:** The RDQ has favorable reliability and validity properties, and is an easy to use instrument for assessing readiness for discharge of inpatients with schizophrenia. The RDQ can be a useful tool in research settings, as it provides a measure of the effects of an intervention on discharge, independent of socio-economic influences.

PMH47

USE AND COST OF POLYPHARMACY IN SCHIZOPHRENIA: DATA FROM A RANDOMIZED, DOUBLE-BLIND STUDY OF RISPERIDONE AND QUETIAPINE

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OBJECTIVES: The use of concomitant antipsychotics and other psychotropics and the costs of polypharmacy in patients randomized to risperidone or quetiapine were examined in a prospective double-blind study. **METHODS:** Subjects were patients with an acute exacerbation of schizophrenia or schizoaffective disorder. In a 14-day phase, patients were randomized to risperidone, quetiapine, or placebo monotherapy. In the following 28-day additive-therapy phase, clinicians were allowed to add antipsychotics or other psychotropics (including antidepressants, anxiolytics, mood stabilizers and sedative/hypnotics). Doses of risperidone or quetiapine were fixed in the additive therapy phase. **RESULTS:** Mean (±SD) doses at monotherapy endpoint were 4.7 ± 0.9 mg/day of risperidone and 579.5 ± 128.9 mg/day of quetiapine. Among 133 patients randomized to risperidone, 33% received additional antipsychotics and 36% received one or more psychotropics (including antipsychotics). In the quetiapine group (N = 122), 53% and 53% received additional antipsychotics or psychotropics, respectively ($P < 0.005$ vs. risperidone in both). In the placebo group, 57% received antipsychotics and 62% psychotropics. The relative risk (quetiapine vs. risperidone) for antipsychotic polypharmacy was 1.90 (95% CI 1.29–2.80). Improvements in PANSS total scores were significantly greater in patients receiving risperidone than quetiapine or placebo at monotherapy endpoint ($P < 0.001$) and significantly greater with risperidone than placebo at the additive-therapy endpoint ($P < 0.01$); quetiapine–placebo differences were not significant. The mean costs of antipsychotic polypharmacy (for the duration of the additive-therapy phase) per randomized patient were $57.03 in the risperidone group and $101.64 in the quetiapine group ($P < 0.05$). The costs of the primary antipsychotic plus the additional antipsychotics were $354,339 in the risperidone group and $524,319 in the quetiapine group. **CONCLUSIONS:** The results confirm earlier observations of higher rates of polypharmacy with quetiapine than with risperidone. These findings suggest that differential costs associated with polypharmacy can be substantial.

PMH48

SYSTEMATIC REVIEW ON RELAPSE AND ANTIPSYCHOTIC NON-ADHERENCE IN SCHIZOPHRENIA

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OBJECTIVE: This study aims to conduct a systematic review on the literature concerning relapse and non-adherence in schizophrenia patients in eight countries (Australia, Canada, France, Germany, Italy, Spain, UK, and US). **METHODS:** As of September, 2004, a literature search was performed in a number of databases including MEDLINE (1966–2004), EMBASE (1980–2004), PsycINFO (1967–2004), Cumulative Index to Nursing and Allied Health Literature (1980–2004) and other health technology assessment databases. Of the 1000 retrieved articles, around half were eventually reviewed in full text. **RESULTS:** Although definitions and measures of adherence and relapse between studies were very diverse, the rate of relapse in schizophrenia appeared to be from 40% to 55% for patients not taking the medication, and 14% to 30% for stabilized patients maintained on medication. Conventional antipsychotics tended to have higher rates of relapse than atypical antipsychotics. Most relapses tended to occur within the first year and, as such, many studies had a short follow-up period. The medication adherence rate for patients with schizophrenia ranged from 20% to 90%. This review has found that adherence is affected by environmental factors (e.g. social support), medication factors (e.g. side effects or lack of efficacy), doctor-patient relationship (e.g. lack of knowledge concerning the illness), forgetfulness, and treatment factors (e.g. medication regimes that are too complex). There was substantial evidence that depot medication aids patient adherence. Because current depot medications are available for conventional antipsychotics and risperidone, it was suggested that considerable advantages may be observed when more atypical antipsychotics are used in depot form. **CONCLUSION:** Relapse and non-adherence to antipsychotic agents in schizophrenia patients are quite prevalent and associated with adverse consequences. Furthermore, because treatment adherence appears to be strongly linked with relapse in schizophrenia, it is important that treatment interventions continue to address the problem of medication non-adherence.

PMH49

ESTIMATING ANNUAL US PREVALENCE OF SCHIZOPHRENIA IN 2002

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OBJECTIVES: This study estimates the 2002 annual prevalence of schizophrenia in the US based on administrative claims data analyses and a comprehensive literature review. **METHODS:** The population-specific annual prevalence rates of schizophrenia in the US were estimated separately for privately insured, government insured (Medicare, Medicaid), and uninsured populations. The 2002 annual prevalence for privately insured individuals was calculated based on a de-identified administrative claims database of approximately 3.0 million privately insured beneficiaries covering the period from 1999 to 2003. The 2002 prevalence of Medicaid enrollees was calculated from Medi-Cal claims covering the period from 2000–2002. The 2002 schizophrenia prevalence in Medicare population was calculated as a weighted average of the prevalence rates of Medicaid/Medicare dual eligibles and private insurance program enrollees over 65. Published statistics were used to estimate the prevalence of schizophrenia in the uninsured population. Finally,